

802 Fox Glen Court  
Barrington, Illinois 60010

## Women's Health History

This questionnaire is designed to help us obtain a complete patient history and identify any problem area which will assist the doctor in making a diagnosis. Your cooperation is greatly appreciated.

Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_

1. Any previous x-ray examination of the breast? Yes/No If so, where, when, and results, if known?  
\_\_\_\_\_
2. At what age did you begin menstruation? \_\_\_\_\_ Stop menstruation? \_\_\_\_\_
3. What was the date of your last menstrual period? \_\_\_\_\_
4. Do you have any children? Yes/No How many? \_\_\_\_\_ Age at first pregnancy? \_\_\_\_\_
5. Were your children breast fed? Yes/No Currently? \_\_\_\_\_
6. Have you ever had any of the following on either breast?

	Yes	No	Right	Left	Now
Discharge					
Pain					
Mastectomy					
Biopsy					
Enlargement					
Surgery					
Injections					
Lump					

7. Is there a history of breast cancer in your family? \_\_\_\_\_ Whom? \_\_\_\_\_  
What age at diagnosis? \_\_\_\_\_
8. Are you taking any medications? \_\_\_\_\_
9. Coffee, tea, cola drinks of chocolate usage per day: \_\_\_\_\_  
\_\_\_\_\_
10. Other complaints: \_\_\_\_\_  
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For the doctor's use:

Med Hx: _____	Allergies: _____
Surg Hx: _____	Tobacco: _____
Meds: _____	ETOH: _____
	Recreational Drugs: _____